DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to follow physician's orders for medication administration for four residents (#15, #22, #25, #36) of 37 residents reviewed for medication administration. The findings included: Review of facility policy, Identifying and Managing Medication Errors and Adverse Consequences, revised April 2007, revealed "...The staff and practitioner shall try to prevent medication errors and adverse medication consequences, and shall strive to identify and manage them appropriately when they occur. The staff and practitioner shall strive to minimize adverse consequences by: (a) following relevant clinical guidelines and manufacturer's specifications for use. (b) defining appropriate indications for use..." Medical record review revealed Resident #15 was admitted to the facility on 9/30/16 and readmitted on 11/22/16 with diagnoses including Seizures, Atherosclerotic Cardiovascular Disease, Gastroesophageal Reflux Disease, Cerebrovascular Accident with Hemiplegia, and Vascular Dementia.	F 281	1)- Finding: During a med pass audit completed by the state surveyor on 12/12/16, an incorrect dosage of Remeron was administered to RI #36. **RI #36** was assessed by Director of Nursing on 12/13/16 and found to have stable vital sign and no signs of distressed observed. MD and family notified on 12/13/16 by the licensed nurse with no new orders received. The license nurse has completed a behavior monitoring tool daily for December on each shift and no signs of depression or adverse side effects have been identified as a result of the medication error that occurred on 12/12/16. RI# 36 was re-assessed by MD on 12/15/16 and found to have no negative effects as a result of the medication error. A medication error report was completed on 12/12/16. LPN #1 was provided one on one education regarding following the 6 rights to medication administration on 12/13/16 by the Director of Nursing Services as well as the Director of Nursing stayed with this Licensed Nurse on 12/13/16 the entire night shift providing direct support and assistance	12/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 12/16/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 1 Medical record review of the 5 day Minimum Data Set (MDS) dated 11/29/16 revealed Resident #15 was moderately impaired cognitively. Continued review of the MDS revealed Resident #15 required extensive assistance with transfers, dressing, and grooming; was dependent for feeding and bathing; and was always incontinent of bowel and bladder. Medical record review of physician's orders dated 12/6/16 revealed an order for "...Lasix 40 milligrams (mg) IM (intramuscularly) x1 (1 dose)..." which was documented as administered. Continued review of orders dated 12/7/16 revealed orders for "...Lasix 40 mg IM x1..." and "...Lasix 20 mg po (orally) daily for pulmonary edema..." Medical record review of the Medication Administration Record (MAR) revealed one sheet with the Lasix 40 mg IM documented as administered on 12/8/16 at 3:00 PM. Continued review revealed Lasix 20 mg one tab by mouth daily was documented on the MAR and scheduled for 9:00 AM but no doses were signed off. Further review revealed a second MAR, undated, with Lasix 20 mg PT (per tube) daily scheduled for 9:00 AM and documented as administered on 12/8/16, 12/9/16, 12/11/16, and 12/12/16. Medical record review of nursing notes dated 12/13/16 revealed "...Noted resident not getting Lasix 20 mg PT daily ordered on 12-7-16, (named physician) made aware and new order to start Lasix 20 mg PT daily x 5 days..." Medical record review of the MAR for December 2016 revealed an undated entry for Lasix 20 mg	F 281	to ensure the nurse performed her duties timely and accurately. This nurse was placed back in orientation on 12/14/16 with the supervisory observation of another license nurse until she is able to demonstrate Medication Administration competencies. This Licensed Nurse currently continues to have additional license nurse supervision. Finding: During a MAR check completed on 12/13/16 by the facility staff as part of the QA process, it was identified an order for Lasix dated 12/7/16 was missed on 12/10/16. **RI #15** was assessed by the licensed nurse on 12/12/16 and found to have normal vital signs and remained in stable condition. MD was notified on 12/13/16 of the identified medication error and new orders received. A follow up chest X-ray was completed on 12/14/16 with no pleural effusions were detected and results reported to the MD. A new order was received to d/c Lasix on 12/14/16. Family was notified on 12/13/16 of medication error and on 12/14/16 of the Medication changes and X-ray results. RI #15 was re-assessed in person by MD on 12/15/16 and found to be in stable condition with no observed negative outcome as a result of the missed medication.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 2 PT daily x5 days with a start date of 12/13/16 and initialed as administered on 12/13/16 then D/C'd (discontinued). Medical record review of nursing notes dated 12/13/16 at 5:53 PM revealed "...In reviewing MAR lasix found to be administered per order..." Continued review of notes dated 12/14/16 of a note from the Unit Manager, revealed "...This writer notified MD of lasix administration and number of days medication given. Received order to D/C lasix..." Medical record review reveled Resident #22 was admitted to the facility on 12/24/14 with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Gastroesophageal Reflux Disease, Depression, Peripheral Vascular Disease, Dementia, and Diabetes Mellitus. Medical record review of the Quarterly MDS dated 9/3/16 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 3 indicating the resident was severely impaired cognitively. Medical record review of physician's orders dated 1/27/15 revealed an order for Inderal 20 milligrams (mg) twice daily; hold for SBP (systolic blood pressure) < (less than) 100; DBP (diastolic blood pressure) < 60; apical heart rate <60. Medical record review of the MAR for November 2016 revealed on 11/25/16 Resident #22's blood pressure was 104/50. Continued review revealed there was no documentation on the MAR the medication was held. Further review revealed no circle around the initials of the nurse	F 281	LPN #2 has not worked since this occurrence was identified. LPN #2 will receive one on one education from Director of Nursing/Designee regarding the expectation of following the MD orders regarding medication administration prior to returning to work. Finding: During a MAR to physician order audit completed by the facility staff as part of the QA process on 11/29/16, it was identified that an order written for Plavix was not transferred to the MAR and therefore, not administered to the resident. During survey exit it was brought to our attention that there was a MD parameter to hold Propranolol for DBP <60 for RI # 22 and upon MAR review it was identified that the nurse obtained BP on 11/22/16 of 113/54 as well as on 11/25/16 BP of 104/50 and on both occasions it was noted no evidence where the medication was held as directed per the parameters. Noted MD telephone order had been received since the above occurrences to only include SBP and pulse parameters for Propranolol as of 11/30/16.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 3 administering the medication as is the standard when a medication is held. Continued review of nursing notes revealed no documentation the medication was held. During interview on 12/13/16 at 1:27 PM in the conference room, the Director of Nursing (DON) confirmed the DBP was <60 and the medication was not held per physician orders. Medical record review of a Peripheral Vascular Disease consult dated 11/15/16 revealed "...Doppler shows occlusion of left posterior tibial artery. American Heart Association recommends Plavix as alternative to Aspirin in reducing risk of Cerebrovascular Accident, Vascular Death, and Myocardial Infarction in Peripheral Arterial Disease patients..." Medical record review of physician's orders dated 11/2/16 revealed an order for Plavix 75 mg daily for the resident's Peripheral Arterial Disease Medical record review of nursing notes dated 11/29/16 revealed "...Physician...notified of med error r/t (related to) Plavix order. Resident assessed with no side effects R/T med error. NO (new order) written to begin Plavix 75 mg QD (daily). During interview on 12/14/16 at 12:00 noon in the conference room, the DON confirmed the nurses failed to follow physician's orders for the Plavix and failed to administer the Plavix from 11/17/16 - 11/29/16. Medical record review revealed Resident #25 was admitted to the facility on 4/20/16 and readmitted on 9/8/16 with diagnoses including Congestive	F 281	**RI #22** was assessed by licensed nurse on 11/29/16 and found to have stable vital signs with no evidence of any negative outcomes as a result of the medication error. MD and family notified of medication error on 11/29/16. Follow-up labs will be completed as ordered by MD to ensure effectiveness of the medication. On 11/29/16, a medication variance report was completed by the Director of Nursing. RI #22 was re-assessed in person by MD on 12/15/16 and found to have not experienced any discomfort or clinical issues that would be a concern to the resident's overall health and safety.RI #22 vital signs noted on 11/22/16 @ 8pm to be stable at 110/62 and pulse of 60 and on 11/25/16 @ 8pm to be stable with a BP of 110/64 and pulse of 72. Noting no negative outcome as a result of the medication error. A medication variance report was completed on 12/15/16 by the Director of Nursing. MD and family notified of medication error on 12/15/16 by licensed nurse. RI #22 was re-assessed in person by MD on 12/15/16 and found to have not experienced any discomfort or clinical issues that would be a concern to the resident's overall health and safety.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 4 Heart Failure, Diabetes Mellitus, Peripheral Vascular Disease, Lymphedema, Chronic Kidney Disease Stage IV, Hypertension, and Gastroesophageal Reflux Disease. Medical record review of the Quarterly MDS dated 10/25/16 revealed Resident #25 scored 15 on the BIMS indicating she was alert and oriented. Continued review revealed Resident #25 required extensive assistance with transfers, dressing, grooming, and bathing; assistance with eating; and was always continent of bowel and bladder. Medical record review of physician's orders dated 11/30/16 revealed Resident #25 was ordered Ultram 50 mg daily. Medical record review of nursing notes dated 12/13/16 for a late entry on 12/12/16 revealed "...Discovered scheduled 9pm Ultram doses for 12/10/16 and 12/11/16 were inadvertently omitted. Daughter & MD notified of med errors..." Review of the Narcotic Administration Record for the resident's Ultram revealed no doses signed out for 12/10/16 and 12/17/16. During interview on 12/14/16 at 10:47 AM in the conference room, the DON confirmed 2 doses of Ultram were not signed out or documented as being administered on 12/10/16 and 12/11/16. Medical record review revealed Resident #36 was admitted to the facility on 4/13/15 and readmitted on 4/1/16 with diagnoses including Anxiety, Hypertension, Dysphagia, Diabetes Mellitus Type II, Depression and Peripheral Vascular Disease. Medical record review revealed a physician's	F 281	LPN #6 was provided one on one education by Quality Assurance Nurse on 11/29/16 regarding 6 rights to medication administration, transcription of physician orders and expectation regarding professional standards of practice. LPN #6 was provided one on one education on 12/15/16 by Director of Nursing/Designee regarding following physician orders, transcription and documentation as a result of the Proprandolol medication error. LPN #6 was placed on a performance improvement plan as of 12/15/16 by the Director of Nursing and will be monitored and reviewed weekly for compliance with medication administration, Physician order transcription. Finding: An order for Ultram written on 11/30/16 was not available until 4 days later due to not having a hard written copy of the order. **RI #25** with a BIMS score of 15 is assessed per shift for pain levels. Since the arrival of the Ultram on 12/5/16 RI #25 has had no complaints of pain. RI	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 order dated 9/9/16 for Remeron (antidepressant) 15 mg (milligram) tablet give ½ tablet (7.5 mg) by mouth at bedtime daily. Observation of Licensed Practical Nurse (LPN) #1 on 12/12/16 at 11:10 PM in the resident's room revealed the LPN administered 2 (two) 7.5 mg tablets to the resident. Interview with LPN #1 on 12/13/16 at 12:10 AM at the Hermitage Nurse Station and medication cart confirmed she had given 2 (two) 7.5mg tablets instead of 1 (one) 7.5mg tablet to Resident #36. Interview with the Director of Nursing (DON) on 12/14/16 at 3:10 PM in the conference room confirmed LPN #1 gave the wrong dosage of Remeron to Resident #36 on 12/12/16, and failed to follow the physician's order.	F 281	#25 was assessed by the Nurse Practitioner on 12/7/16 regarding refusal of medications and respiratory distress with no mention of Osteoarthritis or generalized pain issues. RI #25 was assessed on 12/11/16 by license nurse and found to have effective pain management control in place with no lasting negative affected from the medication error. The resident pain level was assessed by the DON on 12/15/16 was 0 level. RI #25 was re-assessed in person by the MD on 12/15/16 and noted resident to be stable with no discomfort or clinical issues that would be a concern to the resident's overall health and safety. LPN #3 received educational counseling on 12/12/16 by Quality Assurance Nurse regarding process for proper documentation of medication administration and expectations of obtaining meds unavailable when ordered by a physician with the expectation of continued MD follow-up until the script is obtained.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 order dated 9/9/16 for Remeron (antidepressant) 15 mg (milligram) tablet give ½ tablet (7.5 mg) by mouth at bedtime daily. Observation of Licensed Practical Nurse (LPN) #1 on 12/12/16 at 11:10 PM in the resident's room revealed the LPN administered 2 (two) 7.5 mg tablets to the resident. Interview with LPN #1 on 12/13/16 at 12:10 AM at the Hermitage Nurse Station and medication cart confirmed she had given 2 (two) 7.5mg tablets instead of 1 (one) 7.5mg tablet to Resident #36. Interview with the Director of Nursing (DON) on 12/14/16 at 3:10 PM in the conference room confirmed LPN #1 gave the wrong dosage of Remeron to Resident #36 on 12/12/16, and failed to follow the physician's order.	F 281	LPN #4 received educational counseling on 12/12/16 by Quality Assurance Nurse regarding process for proper documentation of medication administration and expectations of obtaining meds unavailable when ordered by a physician with the expectation of continued MD follow-up until the script is obtained. LPN #5 was a temporary contract nurse and her contract was terminated on 12/6/16 and no longer works at the facility. Finding: It was reported during the survey that a complaint was called in alleging that an improper tube feeding was administered. On 12/6/16, the agency nurse indicated an improper tube feeding had been identified by her, but she did not disclose specific resident. **RI #5 (None identified RI for survey)** was assessed by licensed nurse on 11/30/16 and found to have no negative nutritional affects as a result of receiving the incorrect feeding. Incorrect feeding was immediately removed when observed to be incorrect and replaced with correct nutritional supplement as ordered by physician. RI #5 was assessed by the MD on	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 order dated 9/9/16 for Remeron (antidepressant) 15 mg (milligram) tablet give ½ tablet (7.5 mg) by mouth at bedtime daily. Observation of Licensed Practical Nurse (LPN) #1 on 12/12/16 at 11:10 PM in the resident's room revealed the LPN administered 2 (two) 7.5 mg tablets to the resident. Interview with LPN #1 on 12/13/16 at 12:10 AM at the Hermitage Nurse Station and medication cart confirmed she had given 2 (two) 7.5mg tablets instead of 1 (one) 7.5mg tablet to Resident #36. Interview with the Director of Nursing (DON) on 12/14/16 at 3:10 PM in the conference room confirmed LPN #1 gave the wrong dosage of Remeron to Resident #36 on 12/12/16, and failed to follow the physician's order.	F 281	12/15/16 and found to be stable with no negative outcomes as a result of receiving the incorrect nutritional feeding. RI #5 was assessed by Registered Dietician on 12/13/16. LPN #6 received one on one education regarding the 6 rights to medication administration and following physician orders by the Director of Nursing/designee on 12/15/16. 2) A complete audit of all new physician medication orders received from 12/1/16-12/15/16 was completed on 12/15/16 by Corporate Clinical Support team to validate that proper transcription occurred and MD orders are being followed as evidence by completed Medication Administration Record. No other transcription errors were identified and medication administration records were completed as ordered ` As of 12/6/16 when we were made aware of this issue by the Agency nurse a 100% audit was conducted to verify all residents that receive enteral feeding were being providing the appropriate feeding according to the physician orders. No residents were identified to have incorrect enteral feedings provided.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 order dated 9/9/16 for Remeron (antidepressant) 15 mg (milligram) tablet give ½ tablet (7.5 mg) by mouth at bedtime daily. Observation of Licensed Practical Nurse (LPN) #1 on 12/12/16 at 11:10 PM in the resident's room revealed the LPN administered 2 (two) 7.5 mg tablets to the resident. Interview with LPN #1 on 12/13/16 at 12:10 AM at the Hermitage Nurse Station and medication cart confirmed she had given 2 (two) 7.5mg tablets instead of 1 (one) 7.5mg tablet to Resident #36. Interview with the Director of Nursing (DON) on 12/14/16 at 3:10 PM in the conference room confirmed LPN #1 gave the wrong dosage of Remeron to Resident #36 on 12/12/16, and failed to follow the physician's order.	F 281	Pharmacy Nurse Consultant has been conducting Medication Administration Observations of at least 5 license nurses weekly since the first of November and MAR to Cart checks on 100% of the carts each week since the 2nd week of November. 3) Regional Clinical Director/Designee provided education to Nursing Administration Team to include Director of Nursing, Unit Manager, Quality Assurance Nurse, MDS Coordinator, Night Shift RN Supervisor: regarding Medication Administration Record and Treatment Administration Record turnover/end of month process on 12/16/16. In addition the Corporate Support team members will assist with the turnover/end of month process monthly X 6 months to ensure accuracy and competencies. Director of Nursing/Designee began re-education to licensed staff on 12/15/16 regarding 6 rights to medication administration, Medication transcription process, ordering and receiving medications, following physician orders, documentation and professional standards. Education to be continued until 100% of licensed nurses have been educated.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 order dated 9/9/16 for Remeron (antidepressant) 15 mg (milligram) tablet give ½ tablet (7.5 mg) by mouth at bedtime daily. Observation of Licensed Practical Nurse (LPN) #1 on 12/12/16 at 11:10 PM in the resident's room revealed the LPN administered 2 (two) 7.5 mg tablets to the resident. Interview with LPN #1 on 12/13/16 at 12:10 AM at the Hermitage Nurse Station and medication cart confirmed she had given 2 (two) 7.5mg tablets instead of 1 (one) 7.5mg tablet to Resident #36. Interview with the Director of Nursing (DON) on 12/14/16 at 3:10 PM in the conference room confirmed LPN #1 gave the wrong dosage of Remeron to Resident #36 on 12/12/16, and failed to follow the physician's order.	F 281	All new hired license staff to received orientation education by the Director of Nursing/Designee to include 6 rights to medication administration, medication transcription, ordering and receiving medications, following physician orders, documentation, and professional standards. Director of Nursing/Designee to conduct Medication Administration Observations to validate competencies with following physicians orders, documentation & administration with 2 nurses per day to include both shifts daily X 14 days, then 5 license nurses per week X 2 weeks, then 10 license nurses per month X 2 months or until sustained compliance can be reached. Pharmacy Nurse Consultant to conduct additional medication administration observations weekly. Pharmacy Nurse Consultant to conduct a complete MAR to cart check twice weekly X 4 weeks to ensure availability and accuracy of medication to be administered according to physician orders.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 order dated 9/9/16 for Remeron (antidepressant) 15 mg (milligram) tablet give ½ tablet (7.5 mg) by mouth at bedtime daily. Observation of Licensed Practical Nurse (LPN) #1 on 12/12/16 at 11:10 PM in the resident's room revealed the LPN administered 2 (two) 7.5 mg tablets to the resident. Interview with LPN #1 on 12/13/16 at 12:10 AM at the Hermitage Nurse Station and medication cart confirmed she had given 2 (two) 7.5mg tablets instead of 1 (one) 7.5mg tablet to Resident #36. Interview with the Director of Nursing (DON) on 12/14/16 at 3:10 PM in the conference room confirmed LPN #1 gave the wrong dosage of Remeron to Resident #36 on 12/12/16, and failed to follow the physician's order.	F 281	The Pharmacy will place an additional First Dose Medication Cart on the Long term Care Unit when the cart arrives. The Cart will be ordered the week of 12/19/16. Regional Clinical Director/Corporate support to provide clinical oversite conduct validation audits of Medication transcription, Medication Administration and Enteral Feeding accuracy daily for 1 week then 5 days a week for 4 weeks, then weekly until sustained compliance can be reached. Director of Nursing/designee to conduct an audit of 100% of physician orders daily to ensure proper transcription of physician order occurred. On the Weekends the Nurse Manager working will conduct the audits. These audits will include but not be limited to medication orders for pain management to ensure medications are received and available to be administered as ordered per physician orders.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 order dated 9/9/16 for Remeron (antidepressant) 15 mg (milligram) tablet give ½ tablet (7.5 mg) by mouth at bedtime daily. Observation of Licensed Practical Nurse (LPN) #1 on 12/12/16 at 11:10 PM in the resident's room revealed the LPN administered 2 (two) 7.5 mg tablets to the resident. Interview with LPN #1 on 12/13/16 at 12:10 AM at the Hermitage Nurse Station and medication cart confirmed she had given 2 (two) 7.5mg tablets instead of 1 (one) 7.5mg tablet to Resident #36. Interview with the Director of Nursing (DON) on 12/14/16 at 3:10 PM in the conference room confirmed LPN #1 gave the wrong dosage of Remeron to Resident #36 on 12/12/16, and failed to follow the physician's order.	F 281	Director of Nursing/Designee to conduct an audit of 24 hour chart check to validate compliance. Audit to be conducted daily X 14 days, then 5 days per week X 2 weeks, then 10 days per month X 2 months or until sustained compliance can be reached. Director of Nursing/Designee to conduct an audit of residents that receive enteral nutrition to ensure physician orders are being followed audits to be done daily X 14 days, then 5 days per week X 2 weeks, then 10 residents per months X 2 months or until sustained compliance can be reached. The Administrator hired an additional Director of Nursing who is scheduled start date of 12/26/16. The Administrator will continue to aggressively recruit and hire competent license staff to resolve the use of agency staffing and maintain consistent continuity of care. Nine new nurses are scheduled to start orientation within the next 2 weeks on 12/19/16 four starting orientation and a additional 5 scheduled to start 12/26/16. These new nurses will receive orientation and individual needs orientation time scheduled.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 order dated 9/9/16 for Remeron (antidepressant) 15 mg (milligram) tablet give ½ tablet (7.5 mg) by mouth at bedtime daily. Observation of Licensed Practical Nurse (LPN) #1 on 12/12/16 at 11:10 PM in the resident's room revealed the LPN administered 2 (two) 7.5 mg tablets to the resident. Interview with LPN #1 on 12/13/16 at 12:10 AM at the Hermitage Nurse Station and medication cart confirmed she had given 2 (two) 7.5mg tablets instead of 1 (one) 7.5mg tablet to Resident #36. Interview with the Director of Nursing (DON) on 12/14/16 at 3:10 PM in the conference room confirmed LPN #1 gave the wrong dosage of Remeron to Resident #36 on 12/12/16, and failed to follow the physician's order.	F 281	4) Director of Nursing/Designee to present audit findings to the Quality Assurance Performance Improvement Committee meeting every other week X 6 months or until sustained compliance is reached. The Quality Assurance Performance Improvement Committee to include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, MDS Coordinator, Business Office Manager, Social Service Director, Activity Director, Dietary Manager, House Keeping Supervisor and Maintenance Supervisor.	